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ABSTRACT

This report evaluates the Young Mothers' Educational Development Program sponsored by the State University of New York, for pregnant girls between the ages of 16 and 21. The program provided needed services in the areas of obstetrics, pediatrics, education, social work, nursing, and psychology. The girls were Black, Caucasian, and Indian. Internalized values and preconceptions of staff members, reflecting a white, middle class orientation, became apparent during the course of the program. The report focuses on the inadequacies of initial approaches and assumptions and makes suggestions for improvements. (KG)

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THE EVOLUTION OF A THERAPEUTIC GROUP APPROACH TO SCHOOL-AGE PREGNANT GIRLS

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The Young Mothers' Educational Development (Y-MED) Program has been described in a number of publications and manuscripts.[1,3,4,5,6] Briefly, it is a comprehensive program under one roof for the pregnant adolescent providing needed services in the areas of obstetrics, pediatrics, education, social work, nursing, and psychology. The program is broadly rehabilitative for the adolescent and preventive for her infant. The overall goal is to provide both the mother and the child with the maximum opportunity to lead useful, productive, and fulfilled lives within society. It is our judgment that this goal can be best achieved through a respectful orientation to the girls: acceptance of them and their values at any point in time, but exposure to alternatives as well. Thus a basic goal of the program is to help the girls exercise options based on rational considerations emerging out of meaningful relationships with various staff members. In practice, however, this goal is not always realized. There is not a concensus within our staff regarding "what is right" on many issues. Even though the staff is made up of professionals representing several disciplines, there are no guarantees that we will react to issues such as out-of-wedlock pregnancy, civil rights and liberties,

UD 009 352

contraception, abortion, adoption, etc. differently than any other member of society. Attitudes towards these matters have been developed in all of us since childhood and it is not unusual that they are revealed in our work with the girls at Y-MED. In other words, all of us have and exercise value judgments about these emotionalized issues. Thus the girls' decisions regarding such matters can have less to do with rational considerations and more to do with the internalized value communicated by the various staff members with whom she comes into contact. We cannot eliminate our values but they can become explicit through self-conscious staff discussions. In such instances, we are in a better position to assess their relative influence on the girls, and as well, to examine the flaws in our logic. Thus, one of the goals in developing a therapeutic orientation utilizing group technique at Y-MED was to embrace the introspective-analytic orientation in evaluating our efforts. At three recent meetings[1,2,7] it became apparent that programs all over the country for the pregnant schoolgirl are struggling with the value of social work and psychological services in general and group therapy or counseling in particular. It is hoped that the documenting of our experience will be of some profit to other programs.

Most important, we have attempted through a successive trial approach utilizing varying group techniques to help the girls become more effective in communicating with each other and with the staff, and in developing in them a rational orientation in determining action alternatives.

The Girls

The requirements necessary to enter the Y-MED Program are: (1) to be pregnant, (2) to be under the age of 21, and (3) to not yet have graduated from high school. Those girls under the age of 16 are required to attend school under state law. Those up to the age of 21 can attend on a voluntary basis.

In order for the reader to better grasp the population to which our efforts were geared, Table I is presented.

See page 20 for Table I

It will be noted that the size of the populations involved in our group efforts were respectively 42, 59, and 32. These were the girls who were officially enrolled in the educational aspect of the program during the three time periods. There was of course some carry over from one time period to the other, because at Y-MED a girl can remain in the program for one year after the birth of her baby. The decisions regarding separation from the program are made by our outtake committee in collaboration with the girl. Thus our group attempts involve open groups -- groups where girls leave and arrive at various points during our effort. Also it must be obvious that while we are dealing in our effort with populations under 60 in number, that at any time there may be more than 100 girls still involved in the program because of social work, pediatric, psychiatric, or obstetric follow-up.

Before considering certain features of Table I, the age level of the girls in each attempt should be mentioned. In Attempt I, the age range was 14 to 21 years with a median age of 18.5 years. In Attempt II, the range was 14 to 20 years with a median age of 18.2 years. In Attempt III, the range was 11 to 18 years with a median age of 16.5 years. Note that in our first two attempts, 50% of the girls enrolled were 18 or older. Of the younger 50%, 40% were 16 to 18 years of age. Thus many girls in Attempts I and II were in Y-MED on a voluntary basis. This stands in contrast to Attempt III where 50% of the girls were between the ages of 11 and 16.5 years.

From Table I it can be seen in our third attempt the percentage of married girls dropped to zero. The data on educational level are not available for tabulation, but our clinical impressions suggest that girls in our present attempt are much more geared to educational achievement than in the two previous attempts. In addition, it can be noted that in the third attempt a greater percentage of girls entered without a previous pregnancy (97%) and they came earlier in the pregnancy (36% in the first trimester). Data of particular interest is the relationship between years resided in the county and socioeconomic level. All through our attempts the percentage of girls from the two lowest socioeconomic levels has steadily increased (65%, 72%, 90%). Yet in the third attempt, the percentage of girls residing in the county for less than five years rose to 46% from 18%. Such a relationship suggests that pregnant girls are coming into the city from the outside

setting up residence in the lower socioeconomic areas, and then enrolling in the program. This influx of "outsiders" may be what is generating the clinical impression of a population shift. We seem to be getting more younger, unmarried girls with greater academic motivation and potential.

There has been relative stability regarding racial distribution. When the Y-MED Program first began, 90% of the girls were Negro. Since March 1967, however, the percentage of Negroes has fluctuated between 50% and 60%.

The First Attempt

In our staff meetings it was common to hear that a number of issues of great import to them were discussed informally by the girls. These were such things as the attitude of their own parents towards their pregnancy, foster home care for the baby, the legal or ethical responsibilities of the father, etc. Their concern was rather clear. We felt that a formal forum for such discussions might help them more effectively clarify their positions on these matters, as well as open up the possibility of considering other issues regarding themselves and their relationships to others. We further felt that it was not altogether relevant to assume that the girls perceive the program the same way we do. It seemed reasonable then to meet with the girls not only to help them better understand themselves, but to permit the staff to get a clearer view of their perceptions, so that service could be geared more effectively in terms of their stated needs. With these two goals in mind then -- self-examination by both girls and staff, and program

development -- a group program was begun in March 1967. There were four group leaders -- the director of psychological services, a psychiatrist, an intern who was spending six months in psychiatry, and a social worker. Each group met on a once-a-week basis within the Y-MED building, and each had a total enroll- of eight girls.

There was reason to question the wisdom of such a program. It must be remembered that the girls did not directly ask for it. It was created for them out of what we felt was our sensitivity to their need. This is quite different from traditional group therapy, where the participants are there because they want to be. On the more positive side, however, all of the group leaders found a nuclear group within the group. These 'regulars' seemed to feel that there was profit for them in the meetings. These girls were on a relative basis verbal, bright, and high achievers.

In general, however, we reached very few of the girls through this initial effort. Possibly a major reason for this was our own inflexibility, or insistence on the traditional therapeutic model, and the demand that the girls meet our needs. We were only visible during the allotted 50 minutes; the leaders dutifully asked -- "What shall we talk about today?" -- and at appropriate moments made efforts to reflect, clarify, and/or interpret. It went over like a lead balloon. What we soon came to recognize was the difficulty we were having in perceiving these girls as anything but mature

women and expecting responses from them related to such perceptions. It was very difficult to think of a girl as chronologically, emotionally, and intellectually 14, when her big belly hit us in the seat of our respectability and caused us to transform this child into a woman, chronologically, emotionally and intellectually much older, who had made a mistake but through the benign offerings of psychotherapy would be saved. If the girls needed anything they needed structure and direction and within such a framework would most likely be capable of some self-examination. We provided none of this in our initial attempts.

Another insight we achieved, but one that might have been more obvious, was that the girls did not know us and therefore did not trust us. We deposited ourselves in their midst and asked them for their confidence. Remember they did not solicit our help; we imposed it upon them. In some of the early sessions, the girls wanted to know many personal things about us, about our families, work, and attitudes concerning race relations, about the Y-MED Program, etc. -- the inside stuff. In other words, they were saying "reveal yourselves." We made some effort but it was insufficient. Several of us on the staff really "came across" when we went to the summer camp. With them we sang, cooked, and played and in so doing revealed in action enough of our strengths and weaknesses to justify a mutual intensification of trust.

Finally, we made no effort to organize the groups around age. It became clear that there was a significant qualitative difference regarding attitudes and behavior between the girls over and under 16. The older girls referred to the younger ones as the "little kids", and very little communication between the two groups was apparent.

The program continued for four months. At the end of that time we concluded:

1. We were insufficiently respectful to the girls in that we imposed the program on them, option or choice was eliminated. We violated the basic "value" of the program.

2. We assumed the life experiences of the Negro girls were identical to white, middle-class, married women who were pregnant, and we expected interest, good attendance, and effort at introspection and self-examination. We got none of this but instead enhanced distrust and suspicion -- elements already existent in the girls towards the "white power structure."

3. We overlooked what was obvious. Most of the girls (black and white) came from families where the parents, where existent, provided weak and confused standards. Often the structure of the family was shaky and the girls were subjected to conditions of overcrowding and social interaction of a far different variety than that known to middle-class peers. Motivations, expectations, and aspirations are indeed very

different. Ability to relate to possible helpful authority figures is complicated by mistrust and by previous experiences which reveal authority figures as not always being desirable of confidence. In light of these issues it seemed unreasonable to expect the girls to respond to "a traditional therapeutic approach." We were assuming that the route to autonomy and independence was through a noncoercive, passive, reflective orientation. For the girls this approach could only be perceived as "more of ths same" -- another demand they could not or would not fulfill. They needed some definable limits and within such a structure could be more mobile psychologically.

4. By having a number of leaders meet with a number of groups, the visibility of all of the leaders to all of the girls was diminished. We felt that this added to the suspicion already noted.

The Second Attempt

In the second attempt, we tried to revise the program in view of the conclusions.

Since most of the girls were motivated to continue their education, it was decided to present the program within an educational context, rather than a psychiatric one. Thus, a class period during the school day was utilized in which to do our work.

Rather than organize the girls into small groups, we decided to meet them all together as a class, with the leaders rotating their participation. We felt this would alleviate the distrust and suspicion noted earlier, and would enhance visibility of the psychology staff.

Rather than approach the group with a "What shall we talk about today?" approach, we decided to offer more structure. This took the form of a brief lecture on a prearranged topic with the remainder of the time devoted to a discussion.

Even though we noted a distinction between the older and younger girls previously, we decided to make no division of our girls on this basis. We felt that perhaps this particular issue could be dealt with directly in "class" if it came up.

The "course" began in November 1967 and concluded in June of 1968. No official name was developed for it by us. The girls called it the "psychology course." The "teachers" were two clinical psychologists and an advanced psychiatric resident. The average attendance was 20 to 30 girls in each session. Each meeting was 45 minutes in length. Group leadership was rotated among the three staff members, with each person appearing two consecutive times. The topic chosen usually came from the girls' suggestions, but at times from the group leaders. These included such matters as reasons for intercourse, reasons for pregnancy, contraception, abortion, rape, incest, mothering, fathering, surrender, adoption, divorce, love, and dreams.

In the 10 to 15 minute presentations by the group leaders, the relevant theoretical or research material would be presented in "lay" language. For example, when mothering was discussed, Harlow's research on maternal deprivation with

monkeys was presented and when incest was the topic, anthropological findings were reported.

As the sessions progressed, and rapport was established between group members and leaders, the structure of the sessions changed. The students' participation became more direct and spontaneous while the leaders' verbal contribution decreased. The later sessions were characterized by less formal structure, more interaction, and a greater number of meaningful personal reactions.

Although the sessions became more group centered, there seemed to be a threshhold of minimal structure, beyond which group functioning deteriorated. Possible reasons for this limitation were the rapid turnover of students endemic to a program for pregnant adolescents, the large size of the group, and the students' inability to cope with the anxiety elicited in such nonstructured situations.

In general, group leaders attempted to adjust their behavior to the demands of the situation. When the girls participated actively, the leader would either remain silent or introduce occasional comments or questions. When student participation was less spontaneous, the group leader would become more active. In addition to a lecture and discussion period, films were shown during several sessions. Attempts to promote discussion after the films were not as successful as efforts to involve students without the use of films.

It would be fair to say that the topics discussed were in many instances controversial and emotionalized. The girls were initially anxious about dealing with such matters primarily because they were unsure as to whether the leaders could deal with them. This unsureness led to a considerable amount of "testing" behavior on their part with all of the group leaders. They were certainly not going to reveal or deal with personal aspects of their lives unless they felt that the leaders could take it. All of the leaders suffered to some degree but we were sustained by our own group therapy disguised under the label of supervision. In most supervisory sessions, however, discussion was devoted to deciphering the messages transmitted by the girls as clearly as possible and to let them know that we knew what was going on. We felt that such an approach could be helpful to them in developing better interpersonal communications.

There were moments when we were "on the spot." There was no chance to consult a colleague. Action was called for at these times. The factor that saved the day was the ability to be able to admit to the girls our own anxieties and weaknesses when they were stirred. There was strength in this for them as well as for us.

We found as a result of our effort, an increasing capacity for trust on the girls' part. It revealed itself in their willingness to express themselves on an increasingly more affective basis regarding such topics as intercourse,

civil rights, orgasm, parent-child relationships, etc. Such a progression put into sharp focus the prejudices and stereotypic views that the group leaders had towards the poor, the adolescent, and the Negro. We all wondered why we were so amazed that these girls were able to enter into meaningful, involved, and insightful communication regarding the chosen topics. It certainly oriented us to the possibility that our strongly advocated liberalist positions were primarily cerebral in nature.

Thus in summarizing our second attempt, the following can be said:

1. We were constantly mindful of the issue of options, and tried to provide the context for its exercise as much as possible. The girls selected the topics they wanted and the class could have been dissolved if they so desired.

2. We felt that we overcame distrust and suspicion to a great degree by meeting with the entire student body, by rotating our participation and by operating within an educational rather than a traditional psychiatric context.

3. While we had noted the age factor previously as interfering with communication, we observed in the course of the year that other factors were just as potent, such as the racial factor, the marital factor, the surrender versus the retention of the baby factor. In other words, within the total group there were always significant dimensions around which some girls could have been homogeneously grouped. We elected not to do that and instead dealt with issues directly in the class.

4. The initial structured approach to the meeting seemed profitable. As rapport developed, the time involved in lecture became less and less.

5. The value of the visibility of the psychology staff to all of the girls was demonstrated by the willingness of several of the group members to solicit individual meetings with the group leaders.

All was not perfect in this attempt, however. First of all, there was an obvious factor in our population that we overlooked, primarily because of our persisting desire to operate on a traditional therapeutic basis. Girls were constantly coming in and going out of the group. Some at the beginning of the year had their babies and returned to regular school, and new pregnant girls were being admitted all the time, while some remained throughout the whole year. The leaders were so interested in reducing the lecturing aspect of the "class" that we overlooked the fact that by March, half of the group had not been exposed to anything we had said up to that time. This may have been a partial contributor to the fact that verbal participation, as did attendance, fell off; and there was inattention and "fooling around."

Another issue was that the rest of the Y-MED staff became very interested in what we "head shrinkers" were doing with the girls. Strong staff feelings became apparent; and we were remiss in not maintaining open communication with the other staff regarding these activities. This issue was finally forced for us by having a discussion of the "psychology course"

placed on the agenda for one of the general weekly staff meetings. Once this was done, there was a notable reduction in concern and the development of considerable support for our effort.

The Third Attempt

Our third effort began in September 1968 and is continuing. We have preserved and changed out of the experience of our first two attempts. Before specifically documenting this third effort, it is important to note an overall program development emerging out of the experience the psychology staff had with the classes, as well as other experiences of the obstetrical, nursing, and pediatric staffs. These three divisions of our program have been meeting with the girls regularly since Y-MED began, discussing issues relevant to their specialities. This year each discipline (obstetrics, pediatrics, social work, and nursing) is conducting classes structurally similar to our own. For want of a better name they are simply called "health classes." They meet each day for 45 minutes between 11:15 and noon.

These classes have particular value because they bring staff members, in addition to teachers, into personal contact with the girls, particularly the consulting staff who are not often at the center. Secondly, it gives the girls an opportunity to see and get to know the people they hear about but have little contact with.

Initially, the leaders from these specialities seemed pleased with their efforts. However, as time has gone on, some difficulties have developed. For example, the pediatricians noted that attendance was very poor and many of those that did

attend were noninvolved and in some instances disruptive. After interstaff diccussion, it appeared that the behavior of the girls could be best understood as an expression of anxiety. The question was -- "What were they anxious about?" The answer was obvious. The health classes including the pediatric one, require all the girls to attend. Yet about one-quarter of the girls in the program are planning to surrender their babies. The pediatrician, by the very nature of his speciality, is devoting class time to such matters as feeding the baby, prevention of illness, the need for love, etc. For most of the girls, but especially those giving up their babies, ambivalence regarding their decision is present. Classes offering material relevant to the girls keeping the baby would only heighten the anxiety and guilt of those girls who are surrendering. What to do on the matter has not yet been decided definitively. It seems clear, however, that the pediatric health class may not be relevant to all of the girls in the program.

Regarding our own "course" we have preserved the educational format. However, we have moved our time slot to coincide with other disciplines. We still use the rotating system for group leaders but at the moment the psychology staff has been reduced to two persons. Last year the three leaders were all male. This year there is one male (the author) and one female. It is expected that within the next couple months, another staff member will be added who will be introduced into the course after a reasonable orientation period. The

content of the course this year will be the same as last with the addition of sessions on racial and class differences regarding pregnancy, adoption, surrender, and retention of the baby.

We do not plan to stray from the 15 minute didactic period at the beginning of each session, primarily because new people are always coming in so that we cannot assume continuity of relationship. Also because of this, we plan to repeat topics during the second half of the year. This may cause some overload for students who are with us for the entire year; however, our feeling is that the interactional nature of the meetings constantly creates new issues and new insights.

The response of the girls to our present effort thus far has been notably different than to the first two attempts. Attendance, participation, and the exercise of initiative have all improved. This may be related to the presumed population shift referred to in the earlier part of this paper. We seem to have more girls who are verbal, bright, and high achievers. It may also be related to a more experienced staff, having gone through the first two attempts.

Finally, it is possible by the very fact that we have developed "health lectures" and they are given each day by a different discipline, that we are perpetuating the concept of fractionalized comprehensive services. As the saying goes "everyone has his thing" and perhaps in some instances it is

more important for each of us to do our "thing" than to live out each day the concept of a therapeutic milieu that happens to be staffed by personnel from five different disciplines. This latter is an ideal that is still far in the distance for us. While we have our competencies, we have as well our inter- and intrastaff power struggles, competitions, and rivalries as do almost all other programs. We try to deal with them by confrontation and discussion. Another method is to evaluate any program development in terms of its relatedness to stated program goals. It strikes me that the "health lectures" could be improved in this regard if we did not rigidify them by discipline. Everyone in the program could lead a discussion; there could be outside speakers -- both professional and lay people. The girls could be responsible for leadership as well.

Perhaps these remarks transmit to the reader that we like to think of our effort as a dynamic process, constantly changing and being shaped. With such a view, we are just gearing up for our fourth attempt.

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TABLE I

Characteristics of Y-MED Girls for Each Therapeutic Group Attempt

	Attempt I 3/67-6/67 (N = 42) %	Attempt II 11/67-6/68 (N = 59) %	Attempt III 9/68-present (N = 32) %
Marital Status			
Single	74	76	100
Married	26	24	0
Race			
Negro	57	47	59
White	43	49	34
Indian	0	4	7
Number of Pregnancies Before Entry			
None	78	86	97
One	22	12	3
Two	0	2	0
Financial Assistance			
Welfare	62	58	56
Trimester at Entry			
First	8	11	36
Second	55	56	25
Third	37	33	39
Marital Status of Parents			
Married & Living Together	46	57	52
Separated	38	24	19
One Parent Deceased	8	8	10
Divorced & Remarried	5	3	10
Divorced	3	8	6
Unmarried	0	0	3
Years Resided in County			
0 - 5	22	18	46
6 - 10	19	16	4
11 - 15	59	37	18
16 - 20	0	29	32
Socioeconomic Levels			
I (Highest)	2	2	0
II	22	15	5
III	11	11	5
IV	20	35	45
V (Lowest)	45	37	45